

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032644

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 158

STATE FILE NUMBER

FILED AUG 26 1963

VS 300
Rev. 4/59

1 0497

2 0497

3 2

4 0

5 1

6

7 0

8 2

9 331X

10

11

12 90-0

13 3-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) Carthage		c. CITY OR TOWN Carthage	
Length of stay in 1b 10 yrs		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 920 Poplar St		d. STREET ADDRESS (If outside, give location) 614 E. Macon St	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle MILTON Last SOLOMON		4. DATE OF DEATH Month August Day 7 Year 1963	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-27-73
9. AGE (last birthday) 89		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. engineer		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (City and state or country) Lawrence County, Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Solomon		13b. MOTHER'S MAIDEN NAME not available	
14. NAME OF HUSBAND OR WIFE Byrda Wilson Solomon		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Carthage Mrs. S. M. Solomon, 614 E. Macon, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Arteriosclerosis DUE TO (b) Arteriosclerosis DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 4:15 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year 7-8-60	20f. CITY, TOWN, OR LOCATION Carthage, Mo	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Carthage, Mo	
21. I attended the deceased from 7-8-60 to 8-7-63 and last saw him alive on Aug '62 Death occurred at 4:15 p m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS Carthage, Mo	
22a. SIGNATURE (Degree or title) M. Foster MD		22c. DATE SIGNED 8-8-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 8-10-63	23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery	23d. LOCATION (City, town, or county) Mt. Vernon, Mo
24. FUNERAL DIRECTOR KNELL MORTUARY, Carthage, Mo		25. DATE RECD. BY LOCAL REG. 8-9-63	26. REGISTRAR'S SIGNATURE W. H. Clinton

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AUG 27 1983

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank W. Krell

Licensed Embalmer No. 4440

P. O. Address Carthage, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.